

Day/Employment Services Plan of Service

Date of Plan: _____

Section I

Name: _____ DOB: _____
Address: _____

Primary Contact: _____
Address: _____
Phone: _____

Emergency Contact: _____
Phone: _____

Critical Information:

Type and Frequency of Supervision to be provided:

Medical Information:

Medication taken and common/likely side effects:

Description of assistance to be provided with taking medications:

Any other medical interventions to be provided or for which assistance is needed:

Adaptive Equipment used:

Behavior Support:

Is there a plan to be implemented?
If yes, the plan must be attached.

Transportation:

Describe the person's transportation to and from Day/Employment Services:

Name/Title of Person Completing this section: _____

Signature of the Person/Legal Guardian: _____

**Day/Employment Services
Plan of Service****Section II**

Authorized Service (select one):

☐ Day Activity ☐ Community Supports
☐ Career Preparation ☐ Support Center
☐ Employment Services (Group Placement)

The time the unit(s) of the service will be provided (check one):

☐ A.M. ☐ P.M. ☐ A.M. & P.M. (two units)

This service will be provided as follows:

☐ 5 days/week
☐ Other – Specify: _____

Funding Source:

☐ MR/RD Waiver ☐ Community Supports Waiver ☐ State Funding
☐ Other (Private Pay, etc.)

Goal:

Objective/Intervention:

Method/Strategy:

Projected Completion Date:

Objective/Intervention:

Method/Strategy:

Projected Completion Date:

Name/Title of Person Completing this section: _____

Signature of the Person/Legal Guardian (optional): _____

Date of Section (required only if Section I is a Preliminary Plan): _____